STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G179	A. BUILDING _____ B. WING _____	08/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	5701 13TH STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from August 6, 2008, through August 8, 2008. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a residential population of six women with mental retardation and other disabilities. The findings of the survey were based on observations, interviews at the facility and at two day programs, and a review of records, including unusual incident reports.	W 000		
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure entries in each client's record were signed, for two of the three clients (Clients #1 and #2) included in the sample. The findings include: 1. Interview with Qualified Mental Retardation Professional (QMRP) on August 6, 2008, during the entrance conference revealed Client #1 was admitted to the facility on May 24, 2008. Review of Client #1's habilitation record on August 7, 2008, at 5:06 PM revealed a psychological assessment dated June 26, 2008. Continued review of the client's record revealed the assessment had not been signed by the person that completed the assessment. At the time of the survey, the facility failed to ensure Client #1's psychological assessment had been signed. 2. Review of Client #2's record on August 8,	W 114	W 114 1. Psychology assessment was signed and dated. 2. Recreational assessment was signed and dated. In the future the QMRP will ensure that all assessments are reviewed for completion at the time of receipt and on the monthly QA of the client's records.	8/22/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan L. Sloan RN, BSN, MA | TITLE: VP - Operations | (X6) DATE: 8/21/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 114	Continued From page 1 2008, at 12:29 PM revealed a Recreational Therapy Assessment dated May 4, 2007. The assessment was not signed by the individual that completed the assessment. Interview was conducted with QMRP on August 8, 2008 that verified the facility's failure to ensure the assessment was signed.	W 114		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met the needs of one of the three clients (Client #1) included in the sample. The finding includes: Interview with the day program Case Manager on August 7, 2008, at 10:30 AM revealed that Client #1 had a Individual Support Plan (ISP) meeting approximately a month and half ago (June 2008). As the Case Manager escorted the surveyor to the Client #1's treatment area, she indicated that the client was doing better at the day program since the client's transfer to the new residential facility. At 10:35 PM, Client #1 was observed in her treatment area with the day program staff . A staff member was observed verbally prompting the client to participate in a balancing program. Continued observation and interview with that day program staff, revealed the client was nonverbal. The staff member further revealed that a	W 120	W 120 The Day Program will in service the staff to use the multi modal communication system for the client as soon as the equipment is ordered and received. The S/L pathologist will also use this system at the client's residence.	9/15/08

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W 120	Continued From page 2 communication program was in the process of being developed. Review of the Client #1's habilitation record on August 7, 2008 revealed an Individual Service Plan Development Meeting (ISPDM) was held at the day program dated June 26, 2008. The plan revealed that the interdisciplinary team recommended a communication program for Client #1 that required her to use a multi-modal communication system to express herself at different times throughout the day 50% of the time for 3 consecutive months. Interview with the staff member at 11:09 AM revealed the new program for Client #1 was received in July 2008, but staff had not been trained on how to implement the program. At the time of the survey, the facility failed to provide evidence that the aforementioned program had been implemented as outlined.	W 120		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure family members were promptly notified of significant incidents, for one of three clients (Client #2) included in the sample. The finding includes:	W 148	W 148 The QMRP, Residential Manager and the nurses have been in serviced on Incident Management Policy and Procedures. In the future the IMC and VP Operations will ensure that the Policy is followed and appropriate notifications are completed in a timely manner during the monthly incident review meetings.	8/21/08

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W 148	Continued From page 3 Interview with Qualified Mental Retardation Professional (QMRP) on August 6, 2008, at 9:36 AM revealed Client #2 had a sister that was involved in her habilitation and care. Review of the facility's incident reports and corresponding investigations on August 6, 2008, at 3:19 PM revealed the facility failed to provide evidence that Client #2's sister was made aware of the following incidents: - On July 15, 2007, Client #2 was noted to complain of stomach pain. The client was taken to the emergency room for evaluation and was discharged. - On August 16, 2007, staff reported that Client #2 experienced a seizure and was "unconscious for over five minutes." Emergency medical personnel was notified and the client was taken to the emergency room for evaluation and treatment. - On September 28, 2007, day program staff reported that Client #2 fell while leaving her day program. When the client returned home, she was noted to indicate that her chest was sore and was subsequently taken to the emergency room for chest x-ray. On October 3, 2007, Client #2 was noted to have bruises on her right palm, abrasions on her right shoulder and chin, and the right side of her face was slightly swollen. The client was again taken to the hospital for x-rays. - On July 27, 2008, staff noted that Client #2 appeared to be drowsy and slept the majority of the morning. The client's voice was also noted to be "coarse" and she complained of feeling cold. The client was taken to the emergency room and was admitted with a diagnosis of pneumonia.	W 148		

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W 148	Continued From page 4 - On August 4, 2008, Client #2 was noted to be short of breath. The client was called by staff but failed to verbally respond. Client #2 was taken to the emergency room and was treated and released on the same day. At the time of the survey, the facility failed to provide evidence that indicated Client #2's involved family (sister) was made aware of the aforementioned incidents.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policies that ensured the client's health and safety, for one of the six clients (Client #5) residing in the facility. The finding includes: The facility failed to ensure investigations were reviewed within five working days as required and as evidenced below: Review of the facility's incident reports on August 6, 2008, at 12:21 PM revealed an incident involving Client #5 dated August 30, 2007. According to the report, Client #5 alleged she was in a fight with a staff member. Interview with Qualified Mental Retardation (QMRP) and continued review of the facility's incident reports on August 6, 2008, at 12:23 PM revealed the	W 149	W 149 The QMRP, Residential Manager and the nurses have been in serviced on Incident Management Policy and Procedures. In the future the IMC and VP Operations will ensure that the Policy is followed and appropriate notifications are completed in a timely manner during the monthly incident review meetings.	8/22/08

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W 149	Continued From page 5 aforementioned incident was investigated on September 11, 2007 (twelve days after the incident). Interview was conducted with the QMRP on August 6, 2008, at 12:16 PM to ascertain information regarding the facility's incident management system. According to the QMRP, incidents that were investigated should be completed within five business days. Review of the facility's incident management policy on August 6, 2008 at 4:02 PM verified the QMRP's statement and further revealed that the provider held weekly meetings where the QMRP and Vice President were responsible for reviewing the finalized investigation. At the time of the survey, the facility failed to provide evidence that the Incident Management policy was implemented outlined.	W 149		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure required investigations were reviewed by the administrator or designee within five working days of the incident, for one of the five clients (Client #5) that resided in the facility. The finding includes: Review of the facility's incident reports on August 6, 2008, at 12:21 PM revealed an incident	W 156	W 156 Refer to W 148, W 149	

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W 156	Continued From page 6 involving Client #5 dated August 30, 2007. According to the report, Client #5 alleged she was in a fight with a staff member. Interview with Qualified Mental Retardation (QMRP) and continued review of the facility's incident reports on August 6, 2008, at 12:23 PM revealed the aforementioned incident was investigated on September 11, 2007 (twelve days after the incident). At the time of the survey, the facility failed to provide evidence that the administrator or designee reviewed the results of the investigation within five working days of the incident as required.	W 156		
W 231	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that written goals and objectives were written in measurable terms, for one of the three clients (Client #2) included in the sample. The finding includes: The facility failed to ensure self medication program objectives were written in measurable terms. Observation of the evening medication administration on August 6, 2006 at 4:51 PM revealed Client #2 refused her medications. Review of the client's record on August 8, 2008, at 12:16 PM revealed the client had the following	W 231	W 231 All self medication assessments have been revised. In the future the DON and RN Supervisor will ensure that all self medication programs are written in measurable terms. See attached programs	8/21/08

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W 231	Continued From page 7 self medication program objective: To increase self-esteem by self administering medications. Interview with the Licensed Practical Nurse (LPN) and Qualified Mental Retardation Professional (QMRP) on August 8, 2008 verified that the aforementioned objective was the client's current objective. The LPN was queried to ascertain how the client's success with the program objective was measured. At the time of the survey, the nurse failed to provide evidence of how the client's success with the objective could be determined. The facility failed to ensure Client #2's self medication program objective was written in measurable terms.	W 231		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client received continuous active treatment services, for one of the three clients (Client #1) included in the sample. The finding includes:	W 249	W 249 refer to W 120	

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W 249	Continued From page 8 The facility failed to ensure Client #1's day program communication program was implemented as recommended. (See W120)	W 249		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were administered in compliance with the physician's orders, for one of six clients (Client #5) residing in the facility. The finding includes: Observation of the evening medication administration on August 6, 2008, beginning at 4:51 PM revealed Client #5 received Simvastatin 40 mg. Interview with the medication nurse, on the same evening, verified that the label read the tablet was to be administered at bedtime. It should be noted that review of Client #5's medical record on August 7, 2008, beginning at 3:56 PM confirmed in the July 2008, Physician's Order (POS) that the client was to receive the medication at bedtime for hyperlipidemia. The medication nurse was queried on August 6, 2008, at 5:59 PM to ascertain why the client did not receive the medication at the specified time as prescribed. The medication nurse revealed the facility did not have a nurse present to administer the medication at bedtime. At the time of the survey, the facility failed to ensure Client #5 received her Simvastatin in accordance	W 368	W 368 The facility nurse has corrected the error and the medication will be administered in the evening as prescribed by the PCP. In the future the RN Supervisor will ensure such errors do not occur and that the quarterly QA will prevent this from happening again. See attached POS.	8/21/08

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W 368	Continued From page 9 with the physician's orders.	W 368		

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R 000	INITIAL COMMENTS A licensure survey was conducted from August 6, 2008, through August 8, 2008. A random sample of three residents was selected from a residential population of six women with mental retardation and other disabilities. The findings of the survey were based on observations, interviews, and a review of records, including unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's personnel records on August 8, 2008, revealed that the GHMRP failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for four staff.	R 125	R 125 See attached criminal background checks. In the future, the QMRP, Residential Coordinators and the HR Dept. will ensure that monthly audits are completed to make sure all employee files are kept in a current status.	8/21/08

Health Regulation Administration

Susan L. Sloan RN, BSN, MA — VP Operations — 8/21/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 6, 2008, through August 8, 2008. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a residential population of six women with mental retardation and other disabilities. The findings of the survey were based on observations, interviews at the facility and at two day programs, and a review of records, including unusual incident reports.	I 000		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure all bathrooms were equipped cup dispensers. The finding includes: Observation of the GHMRP's environment and interview with the Qualified Mental Retardation Professional (QMRP) on August 8, 2008 during the environmental inspection, revealed the first floor bathroom utilized by the residents failed to have a cup dispenser for its disposable cups.	I 082	I 082 Disposable cups were provided in the bathroom. In the future the QMRP and the Residential Coordinator will ensure that this does not occur again by completing a monthly environmental QA.	8/21/08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status	I 206		

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I 206	Continued From page 1 would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager (HM) and review of the personnel records on August 8, 2008, beginning at 2:22 PM revealed that the GHMRP failed to provide evidence that current health certificates were on file for six direct care staff and four consultants.	I 206	I 206 See attached health certificates. In the future, the QMRP, Residential Coordinators and the HR Dept. will ensure that monthly audits are completed to make sure all employee files are kept in a current status.	8/21/08
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded (GHMRP) failed to provide evidence of all signed agreements and/or contracts for professional services.	I 274	I 274 See attached signed contract for psychologist and psychiatrist. In the future, the QMRP, Residential Coordinators and the HR Dept. will ensure that monthly audits are completed to make sure all employee files are kept in a current status.	8/21/08

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I 274	Continued From page 2 The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's personnel records on August 8, 2008 failed to provide evidence of a contract or agreement for the pharmacist and psychiatrist.	I 274		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure entries in each resident's record were signed, for two of the three residents (Residents #1 and #2) included in the sample. The findings include: 1. Interview with Qualified Mental Retardation Professional (QMRP) on August 6, 2008, during the entrance conference revealed Resident #1 was admitted to the facility on May 24, 2008. Review of Resident #1's habilitation record on August 7, 2008, at 5:06 PM revealed a psychological assessment dated June 26, 2008. Continued review of the resident's record revealed the assessment had not been signed by the person that completed the assessment. At the time of the survey, the facility failed to ensure Resident #1's psychological assessment had been signed. 2. Review of Resident #2's record on August 8, 2008, at 12:29 PM revealed a Recreational Therapy Assessment dated May 4, 2007. The	I 291	I 291 refer to W 114	

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I 291	Continued From page 3 assessment was not signed by the individual that completed the assessment. Interview was conducted with QMRP on August 8, 2008 that verified the facility's failure to ensure the assessment was signed. [See Federal Deficiency Report Citation W114]	I 291		
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that after medical services were secured, prompt notification of unusual incidents was made to resident' s next of kin, followed by written notice and documentation of the resident's status no later than forty-eight (48) hours after the incident, for one of the three residents (Resident #2) included in the sample. The findings include: Interview with Qualified Mental Retardation Professional (QMRP) on August 6, 2008, at 9:36 AM revealed Resident #2 had a sister that was involved in her habilitation and care. Review of the facility's incident reports and corresponding investigations on August 6, 2008, at 3:19 PM revealed the facility failed to provide evidence that Resident #2's sister was made aware of the following incidents:	I 374	I 374 refer to W 148	

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I 374	Continued From page 4 - On July 15, 2007, Resident #2 was noted to complain of stomach pain. The resident was taken to the emergency room for evaluation and was discharged. - On August 16, 2007, staff reported that Resident #2 experienced a seizure and was "unconscious for over five minutes." Emergency medical personnel was notified and the resident was taken to the emergency room for evaluation and treatment. - On September 28, 2007, day program staff reported that Resident #2 fell while leaving her day program. When the resident returned home, she was noted to indicate that her chest was sore and was subsequently taken to the emergency room for chest x-ray. On October 3, 2007, Resident #2 was noted to have bruises on her right palm, abrasions on her right shoulder and chin, and the right side of her face was slightly swollen. The resident was again taken to the hospital for x-rays. - On July 27, 2008, staff noted that Resident #2 appeared to be drowsy and slept the majority of the morning. The resident's voice was also noted to be "coarse" and she complained of feeling cold. The resident was taken to the emergency room and was admitted with a diagnosis of pneumonia. - On August 4, 2008, Resident #2 was noted to be short of breath. The resident was called by staff but failed to verbally respond. Resident #2 was taken to the emergency room and was treated and released on the same day. At the time of the survey, the facility failed to	I 374		

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I 374	Continued From page 5 provide evidence that indicated Resident #2's involved family (sister) was made aware of the aforementioned incidents.	I 374		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for one of the three residents (Resident #2) included in the sample. The finding includes: Review of the facility's incident reports and interview Qualified Mental Retardation Professional (QMRP) on August 6, 2008, beginning at 3:19 PM, revealed the following incidents were not reported as required: - On September 28, 2007, day program staff reported that Resident #2 fell while leaving her day program. When the resident returned home,	I 379	I 379 refer to W 148	

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I 379	Continued From page 6 she was noted to indicate that her chest was sore and that day was subsequently taken to the emergency room for chest x-ray. On October 3, 2007, Resident #2 was noted to have bruises on her right palm, abrasions on her right shoulder and chin, and the right side of her face was slightly swollen. The resident was again taken to the hospital for x-rays. The facility failed to provide evidence that the DOH was notified of the September 28, 2007 visit to the emergency room. According to the DOH's incident management system, the DOH was notified of the incident on October 3, 2007. - On August 4, 2008, Resident #2 was noted to be short of breath. The resident was called by staff but failed to verbally respond. Resident #2 was taken to the emergency room and was treated and released on the same day. The GHMRP failed to provide evidence that the DOH was notified of the aforementioned incident as required.	I 379		
I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure each resident received	I 437	I 437 refer to W 120	

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I 437	Continued From page 7 continuous active treatment services, for one of the three residents (Resident #1) included in the sample. The finding includes: Interview with the day program Case Manager on August 7, 2008, at 10:30 AM revealed that Resident #1 had a Individual Support Plan (ISP) meeting approximately a month and half ago (June 2008). As the Case Manager escorted the surveyor to the Resident #1's treatment area, she indicated that the resident was doing better at the day program since the resident's transfer to the new residential facility. At 10:35 PM, Resident #1 was observed in her treatment area with the day program staff . A staff member was observed verbally prompting the resident to participate in a balancing program. Continued observation and interview with that day program staff, revealed the resident was nonverbal. The staff member further revealed that a communication program was in the process of being developed. Review of the Resident #1's habilitation record on August 7, 2008 revealed an Individual Service Plan Development Meeting (ISPDM) was held at the day program dated June 26, 2008. The plan revealed that the interdisciplinary team recommended a communication program for Resident #1 that required her to use a multi-modal communication system to express herself at different times throughout the day 50% of the time for 3 consecutive months. Interview with the staff member at 11:09 AM revealed the new program for Resident #1 was received in July 2008, but staff had not been	I 437		

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I 437	Continued From page 8 trained on how to implement the program. At the time of the survey, the facility failed to provide evidence that the aforementioned program had been implemented as outlined. [See Federal Deficiency Report W120]	I 437		